

2018 Medicare Special Needs Plans for Erie County

ORIGINAL MEDICARE		Wellcare Liberty 1-866-530-9491	Wellcare Access 1-866-530-9491	Fidelis Dual Advantage 1-888-343-3547	Fidelis Dual Advantage Flex 1-888-343-3547
		(HMO SNP)	(HMO SNP) MA & QMB	(HMO SNP)	(HMO SNP) MA & QMB
PREMIUMS	\$134	\$0	\$0	\$0	\$0
Deductible	\$183	\$0	\$0	\$25/month OTC Benefit	\$400 Flex Benefit Allowance
PCP Visits	20%**	\$0	\$0	\$0	\$0-20%
Wellness exam	\$0	\$0	\$0	\$0	\$0-20%
Specialty Visits	20%**	\$0	\$0	\$0	\$0-20%
Outpatient Mental Health	40%	\$0	\$0	\$0	\$0-20%
Outpatient Substance Abuse	20	\$0	\$0	\$0	\$0-20%
Outpatient Surgery	20% **	\$0	\$0	\$0	\$0-20%
Emergency Care	20% **	\$0	\$0	\$0	\$0-20% Worldwide
Urgent Care	20% **	\$0	\$0	\$0	\$0-20% Worldwide
Ambulance Services	20% **	\$0	\$0	\$0	\$0-20%
Durable Medical Equipment	20% ** (must use supplier enrolled w/Medicare)	\$0	\$0	\$0	\$0-20%
Prosthetic Devices	20% **	\$0	\$0	\$0	\$0-20%
Diagnostic Radiology	20%	\$0	\$0	\$0	\$0-20%
X Rays	20% **	\$0	\$0	\$0	\$0-20%
Lab Services	\$0	\$0	\$0	\$0	\$0-20%
Dialysis	20%	\$0	\$0	\$0	\$0-20%
Radiation Therapy	20%	\$0	\$0	\$0	\$0-20%
Chiropractic Care	limited coverage 20% **	\$0	\$0	\$0	\$0-20%

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		(HMO SNP)	(HMO SNP) MA & QMB	(HMO SNP)	(HMO SNP) MA & QMB
PREMIUMS	\$134	\$0	\$0	\$0	\$0
Deductible	\$183	\$0	\$0	\$25/month OTC Benefit	\$400 Flex Benefit Allowance
Transportation	NOT COVERED	\$0 (24 one-way trips/yr)	NOT COVERED	\$0	\$0 (14 one-way trips/yr)
Medically Necessary Foot Care	limited coverage 20% **	\$0	\$0	\$0	\$0-20%
Routine Foot Care	NOT COVERED	Not Covered	Not Covered	\$0	\$0-20%
P.T.,O.T. and Speech Therapy	20% **	\$0	\$0	\$0	\$0-20%
Inpatient Hospital	\$1,340 deductible	\$0	\$0	\$0	\$0 or \$1,316 deductible for days 1-60; \$329/day for days 61-90 \$658/day for days 91-150
Inpatient Mental Health*	\$1,340 deductible	\$0	\$0	\$0	
Skilled Nursing	0 days 1-20, \$167.50 days 21- 100	\$0/day days 1-100	\$0/day days 1-100	\$0/day days 1-100	\$0/day days 1-20 \$164.50/day for days 21-100
Home Health Care	\$0	\$0	\$0	\$0	\$0
Mammograms	\$0	\$0	\$0	\$0	\$0
Bone Mass	\$0	\$0	\$0	\$0	\$0
Colorectal Screening Exams	\$0	\$0	\$0	\$0	\$0
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0	\$0	\$0

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		(HMO SNP)	(HMO SNP) MA & QMB	(HMO SNP)	(HMO SNP) MA & QMB
PREMIUMS	\$134	\$0	\$0	\$0	\$0
Deductible	\$183	\$0	\$0	\$25/month OTC Benefit	\$400 Flex Benefit Allowance
Prescription Drugs	0%-20% Part B covered only;NO PART D	\$0/\$1.25/\$3.35/\$3.70/\$8.35 0% Part B	\$0/\$1.25/\$3.35/\$3.70/\$8.35 0% Part B	Copays \$0, \$3.35, or \$8.35 No Deductible Part B: \$0-20%	Copays \$0, \$3.35, or \$8.35 No Deductible Part B: \$0-20%
Vision Services	20% + for 1 pair glasses/frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per yr for diabetics	\$0 Exams;\$200 routine eyewear allowance	\$0 Exams;\$100 routine eyewear allowance	\$0 :post cataract glasses/contacts;\$0:glasses /contacts every two years;\$0:Medicare covered exam yearly	\$0 :post cataract glasses/contacts;\$0: glasses/contacts yearly;\$0:Medicare covered routine exam
Hearing Services	40% + Medically necessary exams only no aides	\$0 Exams \$350 Hearing Aid Allowance	\$0 Exams \$350 Hearing Aid Allowance	\$0 Routine Exams	\$0-20% Routine Exams; Flex Benefit Available For Hearing Aids
Diabetic training and supplies	20%	\$0	\$0	0%	\$0-20%
Dental Coverage	limited coverage	\$0: 2 Exams, 2 Cleanings per yr, 1 x-ray every 1-3 yrs	Not Covered	\$0 Exam, Cleaning, Flouride Treatment 1x/yr, X-ray every 2 yrs	\$0-20% Exam, Cleaning, Flouride Treatment 1x/yr, X-ray every 2 yrs
With full LIS		\$0	\$0	\$0	\$0
With full LIS & EPIC		\$0	\$0	\$0	\$0
Max Out Of Pocket		\$6,700	\$6,700	\$6,700	\$6,700

2018 Medicare Special Needs Plans for Erie County

ORIGINAL MEDICARE		United Health Care Dual Complete 1-877- 505-9101	United Healthcare NHP 1-877- 505-9101	Centers Plan NHC 1-844-274-5227	Independent Health Medicare Family Choice 716-635-4900
		(HMO SNP) MA & QMB	Institutional with MA	Institutional with MA	Institutional with MA
PREMIUMS	\$134	\$0	\$0	\$0	\$0
Deductible	\$183	\$0	\$0	\$0	\$0
PCP Visits	20%**	\$0	\$0	\$0	\$0
Wellness exam	\$0	\$0	\$0	\$0	\$0
Specialty Visits	20%**	\$0	\$0	\$0	\$0
Outpatient Mental Health	40%	\$0	\$0	\$0	\$0
Outpatient Substance Abuse	20	\$0	\$0	\$0	\$0
Outpatient Surgery	20% **	\$0	\$0	\$0	\$0
Emergency Care	20% **	\$0 (worldwide)	\$0	\$0	\$0
Urgent Care	20% **	0 (worldwide)	\$0	\$0	\$0
Ambulance Services	20% **	\$0	\$0	\$0	\$0
Durable Medical Equipment	20% ** (must use supplier enrolled w/Medicare)	\$0	\$0	\$0	\$0
Prosthetic Devices	20% **	\$0	\$0	\$0	\$0
Diagnostic Radiology	20%	\$0	\$0	\$0	\$0
X Rays	20% **	\$0	\$0	\$0	\$0
Lab Services	\$0	\$0	\$0	\$0	\$0
Dialysis	20%	\$0	\$0	\$0	\$0
Radiation Therapy	20%	\$0	\$0	\$0	\$0
Chiropractic Care	limited coverage 20% **	\$0	\$0	\$0	\$0

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		(HMO SNP) MA & QMB	Institutional with MA	Institutional with MA	Institutional with MA
PREMIUMS	\$134	\$0	\$0	\$0	\$0
Deductible	\$183	\$0	\$0	\$0	\$0
Transportation	NOT COVERED	\$0 (48 one-way trips/yr)	\$0 (18 one-way trips/yr)	Not Covered	\$0 (20 one-way trips/yr)
Medically Necessary Foot Care	limited coverage 20% **	\$0	\$0	\$0: exams/ treatment for diabetes-related nerve damage	\$0
Routine Foot Care	NOT COVERED	\$0 (4 visits/yr)	\$0 (2 visits/yr)	\$0 (10 visits/yr)	\$0 (7 visits)
P.T.,O.T. and Speech Therapy	20% **	\$0	\$0	\$0	\$0
Inpatient Hospital	\$1,340 deductible	\$0/day for days 1-90	\$0	\$0	\$0
Inpatient Mental Health*	\$1,340 deductible	\$0/day for days 1-90	\$0	\$0	\$0
Skilled Nursing	\$0 days 1-20, \$167.50 days 21- 100	\$0/day for days 1-100	\$0	\$0	\$0
Home Health Care	\$0	\$0	\$0	\$0	\$0
Mammograms	\$0	\$0	\$0	\$0	\$0
Bone Mass	\$0	\$0	\$0	\$0	\$0
Colorectal Screening Exams	\$0	\$0	\$0	\$0	\$0
Flu, Pneumonia & Hepatitis B	\$0	\$0	\$0	\$0	\$0

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		(HMO SNP) MA & QMB	Institutional with MA	Institutional with MA	Institutional with MA
PREMIUMS	\$134	\$0	\$0	\$0	\$0
Deductible	\$183	\$0	\$0	\$0	\$0
Prescription Drugs	0%-20% Part B covered only;NO PART D	Copays \$0/\$1.25/\$3.35/ \$3.70/\$8.35/15% Part B \$0	Copays \$0/\$1.25/\$3.35/ \$3.70/\$8.35/15% Part B \$0	Copays 20% Part B: \$0	Copays \$4/\$15/25%/25%/33% Part B \$0
Vision Services	20% + for 1 pair glasses/frames/contact lens after cataract surgery 20% + coverage for retinopathy exam 1 per yr for diabetics	\$0 Exams, \$0 Post Cataract Eyewear, \$0 every 2 yrs; allowance up to \$300 for routine lenses/frames/contacts	\$0 Exams, \$0 Post Cataract Eyewear, \$0 every 2 yrs; allowance up to \$150 for routine lenses/frames/contacts	\$0: Exams \$, upto \$100 glasses allowance per 2 yr,\$0 post cataract surgery glasses	\$0 Exams, \$0 Routine Eyewear up to \$100 per year
Hearing Services	40% + Medically necessary exams only no aides	\$0 Exams, \$2,000 Hearing Aid Allowance every 2 yrs	\$0 Exams, \$1,600 Hearing Aid Allowance every 2 yrs	\$0 Exams; \$600 Hearing Aid Allowance every 3 yrs.	\$0 Routine Exams, No Hearing Aid Coverage
Diabetic training and supplies	20%	\$0 Training, \$0 Shoes or Inserts, \$0 Supplies (covered brands)	\$0 Training, \$0 Shoes or Inserts, \$0 Supplies (covered brands)	\$0 training ,supplies & therapeutic shoes	0
Dental Coverage	limited coverage	\$0 for Covered Services, \$3,000 limit	Generally Not Covered	\$0 copay: 2 Cleanings,2 x-rays; 2 Exams	Not Covered
With full LIS		\$0	\$0	\$0	\$0
With full LIS & EPIC		\$0	\$0	\$0	\$0
Max Out Of Pocket		\$6,700	\$3,000	\$3,400	\$3,000